

# CORRESPONDENCE

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## Catastrophic failures of public health

Sir—The arresting title of your Editorial<sup>1</sup> (Mar 6, p 745) certainly caught my attention. It compares the “old” epidemics of infectious diseases (and the allegedly successful public-health response to them) with the new epidemic of obesity, and the apparently complacent public-health response to it. But is it a true picture, both of the past and the present?

The public-health “greats” (Semmelweis, Jenner, Virchow, and Snow) all had their share of resistance, and their reforms took decades before the public at large was to benefit. In fact, getting doctors to wash their hands remains a challenge long after Semmelweis’ demonstration,<sup>2</sup> immunisation programmes are still being challenged, and Virchow’s call for attention to poverty reduction for health improvement remains largely unheeded in most countries.

Building healthy cities used to be a matter of clean running water, sewage, waste disposal, food-safety legislation, and improved personal hygiene. Now that these things have largely been achieved in wealthy countries, we see that a healthy city also needs to encourage physical activity in safety and provide transport alternatives to motor cars, preferably footpaths and bikeways. The global obesity epidemic is relatively new, emerging only in the 1980s, and a full understanding of its multiple environmental causes and effect on public-health is also relatively recent.

Having said that, one of the truly frustrating aspects of the “new” public health is engaging all the stakeholders in policy solutions, many of whom have yet to be convinced that they have a role in obesity prevention. These include local government planning authorities, state departments of transport, schools, food regulators, fast-food chains, television advertising regulators, and real estate developers, among others. Powerful vested interests in the status quo (the food and car industries for example) further complicate the political process. Past experience at a state level in Australia (where public-health legislation is based) is that major policy initiatives that cut across government jurisdictions need leadership and direction from the Office

of the State Premier, preferably supported by national policy and funding.

So your suggestion that obesity prevention be taken out of the Ministry of Health portfolio and put into Finance Ministries makes sense and needs testing. Compared with the job ahead for us all though, blaming public-health physicians alone for prevarication on this huge problem seems a little too easy.

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- 1 The Lancet. The catastrophic failures of public health. *Lancet* 2004; **363**: 745.
- 2 Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients’ care. *Lancet* 2003; **362**: 1225–30.

Sir—Your Editorial<sup>1</sup> on the catastrophic failures of public health strikes a real chord. In addition to emerging and re-emerging infectious diseases and unresolved problems of deprivation, public health is haunted by its persistent failings with respect to obesity and its associated health problems. Why are we getting—and dying from being—fat? Public health might have failed us, but so have the societal arrangements that result from established market economies. Incidentally, the economic successes of the west might have fuelled our present obesitogenic environment and culture. Try finding a flight of stairs (other than emergency exits) in any modern public building of moderate height! Sadly, public health is also a victim of this socioeconomic malaise that double-taxes the poor, leaving them fat, sick, and poorer.

The failings of public health can be summarised in four main observations. First, there is a notable absence of the public in public health; it is hardly the “science and art... through organized efforts of society” once envisioned.<sup>2</sup> The members of a society contribute to public health when they participate in and are empowered to act on decisions that affect their health. The rise of consumerism has not been captured by our public-health practices. Second,

the attendant divisive approaches in public-health research and practice do not address the changing public needs and social realities. In fact, the contemporary methods have so embraced aimless empiricism, woolly narratives, and inappropriate (if any) policy analysis<sup>3</sup> that the what, who, how, where, when, and why of population health have remained unaddressed, even in the face of alarming challenges. Third, ramshackle public-health structures are still used to administer poorly defined functions. Ask most people in the health field what exactly public health is, what it does, and who practises it, and you will be lucky to come away with even the Acheson description.<sup>2</sup> It is not surprising that few countries systematically assess and invest in the performance of their public-health systems.<sup>4</sup> Fourth, like most human endeavours today, public-health has a leadership vacuum. Who will defend it? Who will train its practitioners? Who will fund it? Who will garner the intersectoral action needed for health? Who will build and maintain it? I use “will” because I believe we can do these things if we want to.

Meanwhile, we seem poised to dole out scarce funds for expensive health care, only when it is too late. Public health does not promise lower costs because it does not save costs due to averted mortality and increased longevity.<sup>3</sup> However, this line of reasoning misses the point: we simply should not die unnecessarily from conditions amenable to prevention.

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- 1 The Lancet. The catastrophic failures of public health. *Lancet* 2004; **363**: 745.
- 2 Acheson D. Public health in England. The report of the Committee of Inquiry into the Future Development of the Public Health Function. London: HMSO, 1988.
- 3 Fischer F. Reframing public policy. Oxford: Oxford University Press, 2003.
- 4 Centres for Disease Control and Prevention. National public health performance standards program. <http://www.phppo.cdc.gov/nphsp/index.asp> (accessed Mar 17, 2004).

5 Barendregt JJ, Bonneux L, van der Maas PJ. The health care costs of smoking. *N Engl J Med* 1997; **337**: 1052–57.

Sir—In your Editorial,<sup>1</sup> you use the often-cited example of John Snow and the Broad Street water pump handle to illustrate the successful application of a public-health principle for disease prevention and control. You then go on to contrast the successful implementation of these principles to the wider prevention of the public-health scourges of the 19th and early 20th century with a perceived failure of public-health action in the early 21st century. Perhaps these apparent early successes should be viewed with a more realistic perspective.

John Snow was undoubtedly a clear thinking and visionary public-health practitioner. However, he should not be given credit for something that he did not achieve. The Golden Square epidemic was in rapid decline by the time Snow had finished his investigations and suggested to the parish council that the pump handle be removed (figure). However, he had postulated about the waterborne spread of cholera for some time before this outbreak and it was decades before the excess mortality from infectious diseases began to fall substantially. It is salutary to note that much of the fall

was a side-effect of socioeconomic development.

We have known about the public-health consequences of obesity and relative indolence for some time; achieving effective public-health action will, as in the 19th century, take even longer. This is not a catastrophic failure of public health. As 150 years ago, it is likely to be socioeconomic development that has a leading role in dealing with major public-health problems of our age. Nonetheless, there are many current active advocates of public-health policy. Perhaps in 100 years people will regard Richard Doll as the equivalent of Jenner or Richard Peto as the equivalent of Snow.

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- 1 The Lancet. The catastrophic failures of public health. *Lancet* 2004; **363**: 745.
- 2 Snow J. On the mode of communication of cholera. London: John Churchill, 1855.

Sir—Although your Editorial<sup>1</sup> is thought-provoking, contrasting public-health failures in our times with the successes of John Snow, Edward Jenner, Ignac Semmelweis, and Rudolf Virchow will not help the situation.

These public-health heroes

demonstrated the evidence (often painfully in the cases of Semmelweis, Virchow, and even Jenner) for harmful or beneficial public-health practices and sociopolitical conditions. By the same token, epidemiologists around the globe have repeatedly shown which are bad fats and good fats, the merits of dietary fibre, the benefit of physical exercise, and the protective effects of micronutrients. However to bring science into action against obesity and other forms of malnutrition, we need public-health leaders, not heroes, in the community, private sector, and governments alike.

The private sector, seizing the opportunities suggested by clinical and epidemiological evidence, have had pivotal roles in the production, distribution, and consumption of low-calorie food and beverages, dietary fibre, exercise equipment, and other health products. Equally, there has been a call for a paradigm shift in the training of medical doctors, from medical care of individuals in hospitals and health centres to promotion of health in the community.<sup>2</sup> But you are right in pointing out that ministries of health still rely on fragmented and ineffective policy options.

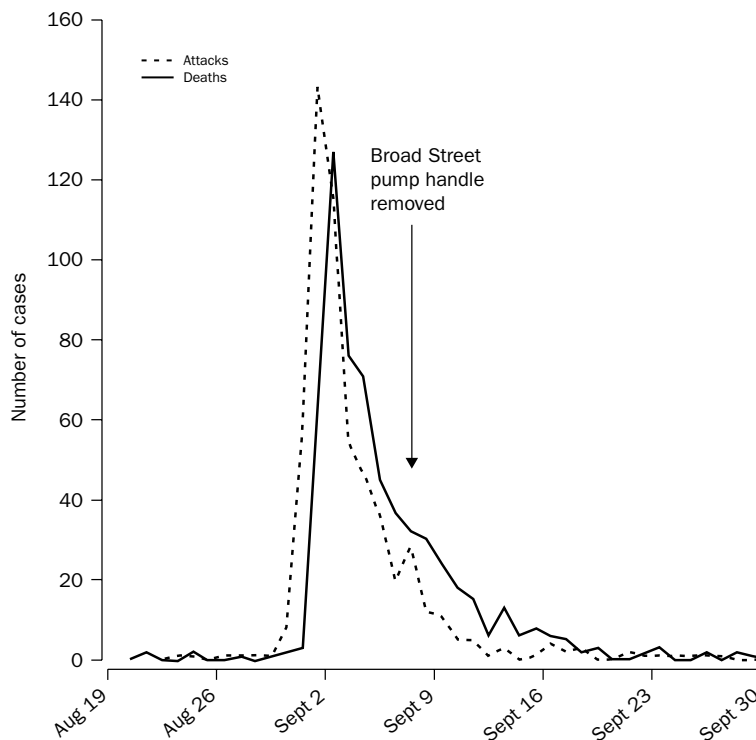
Governments in both poor and rich countries should apply unconventional and lateral thinking in approaching public-health problems creatively. The increasing role of the private sector should not marginalise the leadership of governments in preventing diseases and improving population health.

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- 1 The Lancet. The catastrophic failures of public health. *Lancet* 2004; **363**: 745.
- 2 Jones R, Higgs R, de Angelis C, Prideaux D. Changing face of medical curricula. *Lancet* 2001; **357**: 699–03.

Sir—Your Editorial<sup>1</sup> refers to the “catastrophic failure of public health” in recognising the importance of physical activity. Walking and cycling are simple ideas but sometimes the simplest strategies are the ones that work. One study found that people who cycled to work had 39% lower mortality than those who did not, irrespective of the level of other leisure-time physical activity and the other factors investigated.<sup>2</sup> But who wants to cycle or let their child to cycle to school if it is dangerous? The fear of injuries acts as a barrier to cycling and walking. About 90% of parents worry about traffic hazards on their child's journey to school.<sup>3</sup>



**1854 Golden Square cholera epidemic curve**

Drawn from original data published in reference 2.